NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1291-01
IRO Certificate Number: 5259

July 29, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY
This gentleman was injured on ___. In attempting to treat the lumbar region, this gentleman has undergone IDET twice and other measures to control the report complaints of pain.

REQUESTED SERVICE(S)
Purchase of a Pneumatic vest for lumbar spine control

DECISION
Uphold denial – concur with the pre-authorization determination.

RATIONALE/BASIS FOR DECISION

The standard that has to be applied is, is this a reasonable and necessary item? There is no documentation provided that would indicate any reasonable chances of success or efficacy of the device. This is an investigational device and is not within prevailing standards of care. They are no peer reviewed published studies that have demonstrated the efficacy of this device. A literature and internet search noted several articles based primarily on anecdotal evidence. This search also noted a number of states that have declared this an investigational device not to be reimbursed. With respect to reasonableness of care, the science is simply not there to support the use of this device. Therefore, for all of the reasons noted above, the purchase of this device is not reasonable and necessary.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of July, 2003.